

Changes in the Management of COVID-19

13th March 2020

A report for consideration by the
UK Covid-19 Inquiry and other interested parties



31 July 2024

Revision 1 : 5 March 2026

(Redacted)

CONTENTS

Foreword.....	3
ORIGINAL REPORT (31 July 2024)	4
1. Introduction.....	4
2. Covid-19 Status as an Airborne High Consequence Infectious Disease	5
2.1. HCIDs - A Layman's View	5
2.2. The Declassification of Covid-19 as an HCID : 13 March 2020	6
2.2.1. The date of declassification	6
2.2.2. Chronology of events : 13 th March 2020.....	7
2.2.3. Intervention by the [REDACTED] Team	9
3. Reduced level of Protection for Healthcare Workers	10
3.1. Considerations of HCID status vs RPE Requirements	10
3.2. Timeline – The ‘Evolution’ of the 4-Nations IPC guidance for Covid-19	11
4. Summary Conclusions and Recommendations	15
END OF ORIGINAL REPORT (31 JULY 2024)	17
ADDENDUM (March 2026).....	18
5. Intervention of the [REDACTED] Team	18
6. Declassification – A final note	20

Important Note

This document draws upon information taken from confidential documents disclosed by the UK Covid-19 Inquiry to Module 3 Core Participants. Inquiry rules do not permit disclosure of any such information into the public domain until such times as authorised by the Inquiry Chair. It has therefore been necessary to redact such information from this version of the report. See ‘Foreword’ for more information.

Foreword

This report was originally prepared in July 2024, well in advance of the Inquiry's module 3 hearings. It was written with the expectation that the Inquiry Team would disclose it to all core participants (CPs). It was hoped that this would provide all parties with a better understanding of three important events which occurred within a few hours of each other on Friday 13th March 2020, namely:

- The implementation of version 1.0 of the 4-nations Infection Prevention and Control guidance;
- the downgrading of respiratory protection from Respiratory Protective Equipment (RPE) such as FFP3 respirators to the so-called "PPE", namely Fluid Resistant Surgical Masks (FRSM); and
- the declassification of Covid-19 as a High Consequence Infectious Disease (HCID).

These events have been the subject of much conjecture and speculation. This report clarifies the relationship between these three events. It also pinpoints the crucial moment at which the downgrade from RPE to FRSM occurred, this being the issue of a CAS alert (Central Alerting System) issued by Professor Chris Whitty late in the evening of 12 March 2020. History may record this as the most damaging single moment in the history of the NHS in terms of subsequent healthcare worker death and chronic disease.

There was, however, one particular document which CATA knew existed and needed in order to properly complete the account of what happened on that day (reference INQ000151594).

CATA's legal team at Saunders Law submitted this report to the Inquiry on 31 July 2024, with a request embedded within the report for document INQ000151594 to be disclosed to module 3 CPs (see section 4, [Recommendation 2](#)). However it was not forthcoming.

It is disappointing that the Inquiry would not disclose this document to module 3 CPs, since it had been disclosed to module 2 CPs. (CATA was not a CP in module 2). The context of the document related to communications between senior officials concerning the declassification of COVID-19 as a High Consequence Infectious Disease. This is clearly a matter of relevance to the healthcare sector and the request for disclosure did not seem unreasonable.

The document in question was therefore obtained via a different route (outside of the Inquiry framework i.e. by Freedom of Information Request to DHSC) and an addendum has been prepared at section 5 below which discusses this and other matters.

CATA was disappointed that the Inquiry did not disclose this whole report to other core participants back in August 2024. As explained above, the purpose of this report was to inform all parties and enable the CP legal teams to develop appropriate lines of questioning for state witnesses at the public hearings.

The Inquiry's "Core Participant Protocol"¹ creates a legitimate expectation amongst CPs that **all** relevant documents will be disclosed to them. This report, relating to a serious deterioration in health and safety arrangements for protection of frontline healthcare workers, was absolutely relevant to core participants in module 3.

Given the need for revision once the missing document had been obtained, the opportunity was taken to make some minor amendments to the text of the original report where new information had come to light during the intervening 18 months.

CATA members are subject to a 'Confidentiality Undertaking' (CU) which they and all CPs have had to sign to Baroness Hallett. Breach of a CU is punishable with a fine or imprisonment. All documents which have been disclosed to CPs via the Inquiry's 'RELATIVITY' system are subject to that confidentiality unless they are already in the public domain or have been written by the person themselves. Since this report references numerous confidential documents it has been necessary to redact large swathes of text from this version of the report which has been placed in the public domain. These redactions are either a description of the contents of the document or discussion about them.

In this version of the report all data derived from confidential documents have therefore been carefully redacted. The following conventions are adopted in order to distinguish confidential from non-confidential documents:

- Footnotesⁿⁿ : red text highlighted in yellow relate to a confidential Inquiry document.
- Redaction of text has been implemented via the "_" (underscore) rather than the traditional "■" as this is considered more 'user-friendly' for those wishing to print this report as a hardcopy.

¹ UK COVID-19 Inquiry : Core Participant Protocol ([URL Link](#))

Section 2(a) : "Core participants will be provided with electronic disclosure of evidence relevant to the particular subject matter of the Inquiry in respect of which they are so designated, subject to any restrictions made under section 19 of the Inquiries Act 2005"

ORIGINAL REPORT (31 July 2024)

1. Introduction

On Friday 13th March 2020, two key decisions were made which have been the subject of considerable controversy:

- i) The declassification of Covid-19 as an airborne High Consequence Infectious Disease (HCID);
- ii) Changes made to the Infection Prevention and Control (IPC) guidance, which included:
 - Removal of any reference to “airborne transmission”, which had been present in previous versions of the guidance, even though all parties involved (especially HSE) knew that to be a relevant hazard;
 - Inclusion of dangerous misinformation that the disease was only spread by droplets. These were defined as being greater than 5 microns which, they said, would only travel a short distance through the air and cross-transmission of the disease would be unlikely beyond a distance of approximately 1 metre. This has no scientific foundation or credibility whatsoever.
 - Removal of any reference to observing “the precautionary principle” when considering the protective measures for the health and safety of healthcare workers (HCWs), which had been present in some versions of guidance. This resulted in the provision of Fluid Resistant Surgical Masks (FRSMs) instead of Respiratory Protective Equipment (RPE) such as FFP3 Filtering Face Piece respirators, despite FRSMs not even being classified as Personal Protective Equipment (PPE) under UK law, let alone RPE.

It is not within the scope of this report to explain the above concepts in detail since the Inquiry has commissioned acknowledged IPC experts to assist its enquiries. These experts have prepared comprehensive reports. It is assumed that anyone reading this report will have read those reports or already be familiar with this subject.

It has long been argued that the decisions made in March 2020 (particularly the change in IPC guidance) had a major and detrimental impact upon the health and safety of healthcare workers (HCWs), contracting the disease from their patients and from each other, resulting in avoidable deaths and long-term disease i.e. Post-Covid Syndrome (‘Long Covid’). It has further been argued that staff who became infected in this way then transmitted the disease on to patients, colleagues at work and their families at home. This process is known as ‘Healthcare Acquired Infection’ (also known as ‘nosocomial infection’).

The issue under consideration in this report is whether the decision to declassify the disease as HCID and the downgrade of PPE were linked in any way, bearing in mind that:

- (a) there was a critical shortage of RPE in the country at the time; and
- (b) the declassification of HCID status occurred within a few hours of the RPE downgrade being implemented across the UK. This is further discussed at section 2.2 below, with further comment at section 6.

This led to speculation that the Government no longer classified the disease as ‘high consequence’ in order to justify the withdrawal of the higher level of RPE protection for most healthcare settings – largely because there wasn’t enough RPE to go round. This was vehemently denied by senior healthcare figures at the time (including in evidence to MPs at Select Committees), and since (including written and oral evidence to the UK Covid-19 Inquiry).

Before delving deeper into the events of mid-March, CATA Executive Team wish to whole-heartedly endorse the opinion of the Inquiry-appointed IPC experts, Dr Gee Yen Shin, Prof Dinah Gould and Dr Ben Warne who have opined in their report that the two issues of HCID status and mode of transmission are completely separate². It is entirely possible to declassify a disease as an HCID and still retain the need for enhanced PPE such as FFP3 respirators if the disease presents a hazard to health via the inhalation route.

The route of transmission is not affected by the HCID status and should not have changed from airborne to droplet/fomite only.

² [Expert report by Dr Gee Yen Shin, Prof Dinah Gould and Dr Ben Warne](#) : Infection Prevention and Control – the challenges : paragraph 6.9

2. Covid-19 Status as an Airborne High Consequence Infectious Disease

2.1. HCIDs - A Layman's View

The above-mentioned IPC experts have given an excellent description of the concepts involved with HCIDs. It may be helpful to provide some further explanation – set out more in layman's terms – together with an analogy to assist in understanding.

The concept behind declaring any particular disease as an HCID is a basic principle of pandemic preparedness planning and management. It is founded on the supposition that, in the event of a disease emerging which has pandemic potential, particularly one like Covid-19 which originates in a far-off country, the UK health service will first encounter a relatively small number of infected people.

These patients need to be quickly isolated in order to avoid the disease spreading. They may also be very seriously ill requiring specialist treatment and care. Such patients will be moved to special 'HCID rooms' which are kept under negative pressure (a slight vacuum) so that the contaminated air they emit while exhaling, coughing or sneezing cannot escape from the room into other parts of the hospital.

There are very few of these fully-equipped HCID rooms in the UK. It is of course foreseeable that these rooms may become full, at which point the next stage will be to allocate patients to Infectious Disease Units (IDUs) which, although they do not contain all the facilities of an HCID room, do have negative pressure arrangements to contain the infectious air.

If the surge of cases exceeds IDU capacity, then the next option is to cohort (group) infectious patients into ordinary wards in order to keep them separate from uninfected patients. When this point is reached, there would be no reason to change the level of HCW respiratory protection per se. However, this was not the plan. Disastrous decisions made several years earlier by NERVTAG members were now being implemented³. Sadly those decisions did not allow for the continuation of adequate respiratory protection for the majority of healthcare workers. This had become apparent to the CMO and DCMO by 24th January 2020 when they prepared their paper on 'escalation triggers'. They noted that once HCID and IDU capacity was exceeded "**Likely at this point we will also be drawing on pandemic PPE stockpiles and, to be clear, there will not be enough high-level PPE in this scenario**"⁴.

5.

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This shows that the Inquiry's appointed IPC experts are absolutely correct when they make the point that HCID status and RPE provision are completely unconnected. The disease can be declassified and the high-level PPE still retained. No pathogen changes its route of transmission simply by virtue of a change in its management.

By way of analogy: In 2020, the world was at war – a war against a deadly virus. On the battlefield in a conventional war, it is not uncommon for the generals to adopt a 'trench strategy', with front-line trenches being their first line of defence against the enemy and secondary trenches behind them in case the front-line trenches are overrun.

³ INQ000300331 [NERVTAG Sub-committee on the pandemic influenza facemasks and respirators stockpile, September 2016](#) (B Killingley, J Van-Tam)

⁴ INQ000047541 [UK Escalation Triggers and Response Options, CMO/DCMO](#), 24 January 2020

⁵ [INQ000291635](#)

⁶ [INQ000269921](#)

If the secondary trenches are also overrun and there are no further trenches behind them, then the invading army can make rapid advances without much opposition. At this point there is no sense in continuing with the ‘trench strategy’. We can think of our HCID centres as the front-line trenches, the IDU facilities as the second-line trenches. Once they are “overrun”, there is no point in relying upon the ‘HCID strategy’ – the “horse has bolted” so as to speak.

2.2. The Declassification of Covid-19 as an HCID : 13 March 2020

2.2.1. The date of declassification

The date of 19th March 2020 has been repeatedly cited as the date when the declassification of Covid-19 occurred. This is most definitely not the case. That said, it is easy to see how people have come to believe this to be the case, since that is the date shown on the Advisory Committee for Dangerous Pathogens (ACDP) HCID web page (See fig 1)

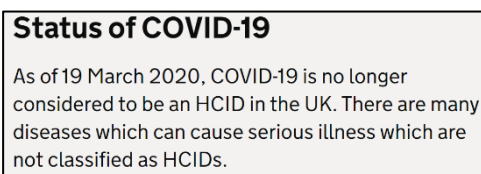


Figure 1: Extract from HM Government [web page](#) “High Consequence Infectious Diseases”, accessed 26 July 2024

This date of the 19th March 2020 has been cited by numerous witnesses (senior figures in Government Departments such as Professor Susan Hopkins⁷ and Professor Sir Chris Whitty⁸) in their written evidence and oral submissions during module 2. Confusingly, in her evidence, Professor Yvonne Doyle also cited 16th March as the date of declassification. Whether knowingly or unwittingly they have misled the Inquiry. A member of CATA’s Executive Team had occasion to write to the Inquiry with concerns over this, and other aspects of Professor Doyle’s evidence⁹. More disturbingly, as will be further discussed below, the Inquiry appears to have been further misled by the

Whilst a difference of 6 days may not seem to be that relevant or significant, some commentators may view it as a very convenient device for those involved in Government to introduce some temporal separation, even if just a few days, between the downgrade in PPE and the HCID declassification to make it appear less likely that the two were inter-connected. Indeed there was a connection between the two, which will be discussed below.

For the avoidance of doubt, an account will now be given of the chronology of events – first as a brief summary, then in more detail:

- 13 March 2020:
 - Two committee meetings were in progress simultaneously, both starting at 11:00. i.e. NERVTAG¹⁰ and ACDP¹¹. These were virtual meetings conducted by teleconference (e.g. zoom). The detail of these meetings will be given in section 2.2.2 below, but the outcome, by the end of both meetings, was that Covid-19 had been declassified and was no longer an HCID.
 - It is clear, from other evidence disclosed to the Inquiry that there was no ambiguity or doubt about this matter. The decision had been made by the authoritative body (ACDP), the disease had been declassified and that was final. There was no suggestion that this decision would need to be ratified by any other group.

⁷ INQ000410867 [Witness Statement #1, Susan Hopkins](#), para 268

⁸ INQ000410237 [Witness Statement #5, Christopher Whitty](#), para 3.35

⁹ Letter [to UK Covid-19 Inquiry : Misleading Evidence by Professor Yvonne Doyle](#) – 5 December 2023

Note: The Inquiry initially published this letter on its website (INQ000366265) but later withdrew it without explanation.

¹⁰ INQ000212195: [Minutes of the New and Emerging Respiratory Virus Threats Advisory Group \(NERVTAG\)](#), 13 March 2020 11:00hrs

¹¹ INQ000223384 [Minutes of meeting of the Advisory Committee on Dangerous Pathogens](#), 13 March 2020 11:00 hrs

- 16 March 2020:
 - Although the ACDP had already declassified the disease, no one had formally sat down and worked out any justification for this against the 6 HCID criteria. A more formal justification was necessary on something as important as this, over and above ACDP's hasty ruling 3 days earlier (decided under "Any other Business").
 - The "4-nations HCID Definition and List Group" which had been involved in the original classification back in January 2020¹² corresponded about this.
- 19 March 2020:
 - After the group had corresponded, their review was published¹³. Their reasoning was sound, based on changes to 2 of the 6 HCID criteria no longer applying:
 - Lower case fatality rate (CFR) than most expected for HCID diseases†
 - Real-time testing was now available to confirm diagnoses.

It should be remembered that the disease had originally been classified as an **airborne** HCID. It should be noted that neither of these two criteria affected the "airborne" categorisation, nor gave any grounds for abolishing the need for 'Airborne precautions' such as FFP3, as specified in the new IPC guidance. No such evidence or rationale was ever given then or since for the change to a droplet paradigm.

† Although a relatively minor point, it should be noted that this group cited a CFR of 1%, when the CMO/DCMO and SAGE were working on the basis of CFR between 2 and 3%¹⁴. It is possible that this group were thinking of Infection Fatality Rate (IFR) which is not the same as CFR since, at the time, the IFR was estimated at 1%. It is also noted that they failed to mention the crucial point that HCID and IDU rooms had been overrun and that the HCID status had now become superfluous and irrelevant.
- 20 March 2020: The incident management team within Public Health England write the new script to be displayed on the ACDP website "**As of 19 March 2020, COVID-19 is no longer considered to be an HCID in the UK etc**"¹⁵.

2.2.2. Chronology of events : 13th March 2020

The sequence of events on that pivotal day in the pandemic will now be considered in more detail:

- As already noted, NERVTAG and ACDP committees were in session simultaneously, starting at 11:00. Both were being conducted by teleconference.
- The ACDP meeting had been convened solely to discuss the arrangements for safe carriage of clinical samples suspected of containing SARS-CoV-2 from nasopharyngeal swabs. No other topic was on the agenda, certainly not HCIDs or PPE for HCWs.
- The NERVTAG meeting discussed the stepdown from FFP3 to FRSM which had occurred the previous evening as a result of the CAS alert sent by the Chief Medical Officer. The status of Covid-19 as an HCID was discussed. Members noted that "there was an argument for reclassification of Covid-19 from an HCID" and that this would need to be done by the ACDP.
 - Although the issue of FFP3 shortages was not discussed at this meeting, members will have been mindful of the supply issues which had been raised at their previous meeting¹⁶. Public Health England, responding to concerns expressed by the Chief Medical Officer, Professor Chris Whitty, changed the IPC guidance with the express intention of preserving dwindling stocks of FFP3 respirators.
- The minutes indicate that Professor Sir Jonathan Van Tam (JVT) then left the NERVTAG meeting and contacted the ACDP Chair, Prof Tom Evans, whilst the ACDP meeting was still in session and conveyed NERVTAG's recommendation that the ACDP should "urgently reconsider the HCID classification".

¹² INQ000223380 [Initial recommendation from the "4-nations HCID definition and list group"](#), 10 January 2020

¹³ INQ000119498 [Review of whether Covid-19 should continue to be classified as a High Consequence Infectious Disease in the UK](#), 19 March 2020

¹⁴ INQ000074987 [SAGE Understanding of Covid-19 \(Case Fatality Rate\)](#) (page 2, row 2), 4 March 2020

¹⁵ INQ000087332 [email from Public Health England's Incident Delivery & Response team : New HCID text for gov.uk pages](#), 20 Mar 2020

¹⁶ INQ000087540 [Minutes of NERVTAG meeting](#) 6 March 2020

- After ACDP finished its business of the day, under “Any other business”, Professor Evans informed members that he had been contacted by DHSC (evidently a reference to the conversation he had just had with JVT). He explained the issues associated with HCID. Evidence exists which suggests that in his account of the conversation to members, Professor Evans made mention of the stepdown from FFP3 to FRSM¹⁷. Members would have known that FFP3 is a requirement for HCW protection when dealing with patients having a disease classified as HCID. Members unanimously agreed that the disease should be declassified.

It is not recorded whether the representatives from HSE were part of the ‘unanimous decision’ as they were only present as “observers/assessors”. One would have thought they would have been quite concerned about the increased risk to healthcare workers and made some representations about this. Later enquiries of HSE revealed that they did not make any such representations. In fact, as shown in the timeline at section 3.2 below, they assisted the IPC Cell in preparing an ‘FAQ’ to reassure them that FRSMs would keep them safe.

- The decision about the declassification is communicated back to the NERVTAG meeting, which was still in session, by Dr Jim McMenamin.
- Professor Evans writes to JVT confirming the ACDP committee members’ decision to declassify.¹⁸

There is no doubt whatsoever that Covid-19 was declassified on that day, the 13th March 2020. This is quite clear from a number of sources:

- the minutes of the NERVTAG meeting on that day which unambiguously state:
High Consequence Infectious Disease (HCID). The Advisory Committee for Dangerous Pathogens (ACDP) and SAGE have declassified COVID-19 and it is no longer a HCID.

Clearly JVT and other NERVTAG members will all have had a good understanding of the role of the ACDP committee and its autonomous authority to rule that a disease can be declassified from HCID status without reference to the “4-nations HCID Definition and List Group” or anyone else. This is evidenced by the fact that they elected to make their representations direct to the Chair of ACDP and not to the HCID-D&L Group.

- ¹⁹

²⁰

The respective roles of the “4-nations HCID Definition and List Group” and the ACDP are helpfully explained by the Chief Medical Advisor of UK-HSA in her witness statement dated 31 January 2024. As a member of the UK-HSA Executive Committee which oversees both groups, she is well positioned to explain the relative roles of these two committees. She writes: ***“At the start the pandemic the four nations public health HCID group was responsible for making recommendations on HCID classifications that went to the Advisory Committee on Dangerous Pathogens (ACDP) to consider, and where appropriate, endorse.”***²¹

¹⁷ INQ000300612 : [BBC Article : ‘How healthcare workers came to feel ‘expendable’](#), David Shukman, BBC Science Editor, 6 February 2021

¹⁸ INQ000130524 [Letter from Tom Evans \(Chair ACDP\) to JVT \(DCMO\) - Declassifying Covid-19 as HCID](#) , 13 Mar 2020

¹⁹ [INQ000381176](#)

²⁰ [INQ000224003](#)

²¹ INQ000410867 : [Witness Statement #1, Susan Hopkins](#), Explains the respective roles of ACDP and 4-Nations public health HCID group, para 265

So the four individuals of the “4-nations group” make recommendations about HCID, but it is the ACDP which has the ultimate authority to decide whether or not to accept the recommendations, formally declare the disease to be an HCID and include it in the official HCID list on the Government website. This confirms the supremacy of ACDP over the “4-nations group” in the hierarchy of HCID decision-making. Logically, the same applies in reverse, when it comes to declassification.

What actually happened during that crucial ACDP meeting may never be known, since the only official record is the brief note under AoB in the minutes of the meeting together with Professor Evans’ short letter to JVT. However, some insight into the conduct of the meeting and the criteria surrounding the members decision to declassify can be found in an article “Covid PPE: How Healthcare workers came to feel expendable”¹⁷, written by the BBC’s Science Editor, David Shukman.

Mr Shukman spoke with an ACDP member (who refused to have their identity revealed) who had attended that meeting. He or she told Mr Shukman that the decision was indeed “pragmatic”, because they all knew that the stockpile of PPE was limited.

It is unfortunate that the Public Inquiry-appointed IPC Expert Witness, Gee Yen Shin who, as a member of the ACDP committee, was unable to attend the meeting of 13th March 2020, since otherwise he would have been able to give an account of the proceedings.

2.2.3. Intervention by the [REDACTED] Team

We now move forward to the public hearings for module 2 and the answers given by JVT to questions put to him by Mr Pete Weatherby KC (Counsel for Covid Bereaved Families for Justice UK) in connection with the NERVTAG meeting and the interaction he had had with ACDP during that meeting²².

23

²² Transcript : 22 Nov 2023 : <https://covid19.public-inquiry.uk/wp-content/uploads/2023/11/23180915/C-19-Inquiry-22-November-2023-Module-2-Day-24-Revised.pdf> pp 226-228

²³ INQ000398305

The account given in this letter does not bear scrutiny because:

- _____

- The agenda for the ACDP meeting on 13th March 2020²⁴ shows _____
- _____

- The only unknown factor is the contents of the email to which the _____ refer (INQ000151594) which is not in the public domain, nor has it been disclosed to module 3 CPs. It is hoped that the Chair will approve this document being made available to Module 3 CPs who understandably have an expectation that, by the end of this module, a very clear, open and transparent picture will be available as to exactly what went on during those difficult days of the pandemic.

Members of the public and interested parties can only go so far, investigating by use of Freedom of Information requests. It needs the authority of the Inquiry Chair to ensure that all relevant documents are made available for public scrutiny so that lessons can be properly learned in order to be properly prepared for the next pandemic.

3. Reduced level of Protection for Healthcare Workers

3.1. Considerations of HCID status vs RPE Requirements

In section (2) above, it was clearly established that “HCID status and RPE provision are completely unconnected. The disease can be declassified and high-level PPE still retained”. At least that is the case in theory. In practice, during the first few months of 2020 it was not as simple as that. Given the health and safety rules pertaining to HCWs working with HCID patients, they have to be equipped with FFP3 or other respirators which afford a similar level of protection. Put simply, you cannot downgrade HCW protection from FFP3 to FRSM whilst the disease is still tagged “HCID”.

These health and safety rules had been agreed with the Health and Safety Executive who had prescribed a particular ‘PPE ensemble’²⁵, which included FFP3 respirators or alternative RPE (but certainly not surgical masks, which are medical devices with the primary function of protecting the patient from the HCW, not the other way around). Scientists at the HSE’s Buxton research centre had done sterling work testing the PPE ensemble for its effectiveness, largely prompted by the Ebola outbreak in Africa²⁶.

Very early in the pandemic the UK’s senior medical officers in the Department of Health and Social Care, knew that once the 50 beds in HCID facilities and the 500 beds in Infectious Disease Units had become overwhelmed then patients would have to be cohorted in general wards and, crucially, the pandemic stockpile of FFP3 respirators would not be sufficient to protect the HCWs working in those wards, nor those in Emergency Departments, ambulances and many more settings^{27 28}. They could only be equipped with FRSMs. This strategy had been decided many years before and is documented in NERVTAG sub-committee meetings in 2016²⁹. Those ill-conceived decisions had now “come home to roost”.

²⁴ [Advisory Committee on Dangerous Pathogens](#) : Agenda for meeting of 13 March 2020

²⁵ [A unified PPE ensemble for clinical response to possible High Consequence Infectious Diseases](#)

²⁶ HSE Expert Microbiologist explains that PPE can be HCWs’ only defence against exposure to a pandemic disease - [Video Interview](#) - 14 Dec 2018

²⁷ INQ000269203 [Witness statement #2 of Jonathan Van-Tam](#), 8 September 2023, para 6.123

²⁸ [INQ000047541 UK Escalation Triggers and Response Options](#), assumed J Van-Tam (by virtue of ‘track change’ initials

²⁹ INQ000300331 [NERVTAG Sub-committee on the pandemic influenza facemasks and respirators stockpile, September 2016](#) (B Killingley, JVT)

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31

Everyone knew that you couldn't downgrade the PPE while the HCID tag was still in place. That said, this did not seem to worry Health Protection Scotland, who downgraded PPE to FRSM on 10th March 2020, regardless of the fact that the disease was still designated as an Airborne HCID³².

It is also noted that all reference to the 'Precautionary Principle' had been removed from their guidance, which had been present in the previous version³³. Some commentators have interpreted that as 'throwing caution to the wind'³⁴.

It was clear at this time that the 'vehicle' for implementing the downgrade from FFP3 to FRSM would be the IPC guidance. At that time the four nations of the UK were all following their own IPC procedures but broadly following the Scottish National IPC Manual. It was agreed between the four nations that a single "4-nations IPC Guidance" document would be put in place. The only one available was that which had been prepared for Pandemic Flu. The evidence suggests that Dr Lisa Ritchie[†] (Health Protection Scotland) and Chair of the "Pandemic Influenza Guidance (Infection Control) Review Group" adapted that document for Covid-19. Her work was 'tidied up' and finalised by JVT before being issued to NHS for implementation.

[†] Referred to as "LR" in the timeline below

3.2. Timeline – The 'Evolution' of the 4-Nations IPC guidance for Covid-19

A chronology of the transformation of the pandemic flu (PandFlu) IPC guidance into Covid-19 IPC guidance is given below. Whilst this may seem over-forensic, it is necessary to break this down into discrete steps in order to understand some of the underlying themes which show that the various actors involved realised the enormity of what was being done here in terms of the potential risk these actions presented to the health and lives of healthcare workers:

Dec 2009 ³⁵	Pandemic Influenza (H1N1) – A summary of guidance for infection control in healthcare settings. PPE requirements were FFP3 respirators for AGPs only, FRSM for (a) entry to cohorted areas but with no patient contact, and (b) Close patient contact (within 1 metre). This ignored (and disrespected) the valuable research carried out by the Health and Safety Executive's expert scientists, just a year earlier, which proved that FRSM would be ineffective protection for HCWs in the case of a pandemic such as influenza and warned against such a strategy³⁶.
Sep 2016 ²⁹	NERVTAG PPE subcommittee recommend FRSM for all general ward, community, ambulance and social care staff in the event of an influenza pandemic. FFP3 for AGP only : Dr Ben Killingley/JVT

³⁰ [INQ000421819](#)

³¹ [INQ000470587](#)

³² [IPC Guidance, Acute Settings, Health Protection Scotland](#), version 9.0, 10 March 2020

³³ [IPC Guidance, Acute Settings, Health Protection Scotland](#), version 8.1, 5 March 2020

³⁴ [INQ000502158 Opening submission on behalf of Covid-19 Bereaved Families for Justice UK](#), Section 4: 'Throwing Caution to the Wind'

³⁵ [IPC Guidance for pandemic flu \(H1N1\)](#), December 2009

³⁶ HSE : [Research Report RR619](#) : Evaluating the protection afforded by surgical masks against influenza bioaerosols – April 2008

2019 ³⁷	
Dec 2019 ³⁸	
26 Feb 2020 ³⁸	
6 Mar 2020 ¹⁶	PHE issue revised IPC guidance – FRSM for suspected cases, FFP3 for confirmed (<i>previously FFP3 for suspected</i>). This was in order to preserve stocks of FFP3 due to looming supply shortages.
10 Mar ³⁸	
10 Mar ³⁸	
11 Mar ³⁸	
11 Mar ³⁸	
12 Mar References ^{39 40}	JVT receives the first draft of what will become version 1 of the 4-nations IPC guidance. The filename of the document (as received by Freedom of Information request from DHSC) is noted to be “2020-02-26-pan-flu-ic-guidance-final-draft LR 110320 adapted for COVID-19-1_MZ comments_Redacted”. This suggests the document was adapted from the latest iteration of the pandemic flu IPC guidance as it was in February 2020. The initials further suggest the editing has been done by Dr Lisa Ritchie of Health Protection Scotland (Chair of the Pandemic Influenza Guidance {Infection Control} Review Group Membership) before being delivered to JVT. This document has an entry in ‘section 1. Introduction’ that the document had been derived from an expert advisory group with representation from the four UK nations. LR was making the point that the document was a ‘four-nation’ initiative, not just HPS in Scotland. This document is interesting in that it lists, on page 48 the full list of people who co-authored and, one presumes, all signed off the document. It is clear that this was a 4-nation initiative It is curious to see that two representatives from HSE were in this group (Dr Brian Crook and Vin Poran), when Dr Crook had co-authored the HSE’s research report RR619 (2008)³⁶ which had advised <u>against</u> the use of surgical masks for protection of HCWs faced with a pandemic (“live viruses found behind every mask tested” etc) now seemingly advocating the use of surgical masks for protection of HCWs facing a pandemic which HSE knew to be airborne⁴¹. One wonders whether he and Mr Poran were consulted before their names were attributed to the draft Covid-19 guidance. This list of names was removed before final publication of the guidance. It should be noted that there is a minor error in Chris Whitty’s 5th witness statement (1/2/2024, INQ000410237) where, at section 6.8 he states that document INQ000381172 is the version of draft guidance sent to JVT by LR with her email to him 12 Mar, 10:42. It is not. It is the final, edited version that JVT sent to Keith Willett later that day.

³⁷ [INQ000381161](#)

³⁸ [INQ000381168](#)

³⁹ [Draft IPC Guidance](#) as sent from Health Protection Scotland (presume LR) to JVT, 12 Mar 2020 (Redactions by DHSC FoI Team)

⁴⁰ [INQ000381171](#)

⁴¹ [INQ000269803 HSE Guidance to Inspectors re social distancing](#): Risk of airborne infection via aerosols greatest within 1 metre. Apr 2020

12 Mar 16:46 ⁴²	JVT forwards this version ³⁹ to Susan Hopkins, Peter Horby and Keith Willett but adds that it is not ready yet and he has further work to do on it.
12 Mar —:— ⁴³	
12 Mar —:— ⁴³	
12 Mar —:— ⁴³	
12 Mar —:— ⁴³	
12 Mar 22:46:25 ⁴⁴	Just 30 seconds after —'s email is received, the 'button is pressed' and the CAS Alert is posted, downgrading PPE from FFP3 to FRSM across the NHS. History may record this as the most damaging single moment in the history of the NHS in terms of subsequent healthcare worker death and chronic disease. The storm of concern, fear and anguish which erupted in the days, weeks, months and years since that fateful mouse-click is another story.
13 Mar	NERVTAG remember that FFP3s are required for HCIDs and realise that the new guidance is in breach of health and safety requirements – prompt ACDP to declassify.
16 – 19 Mar	The “4-nations HCID Definition and List Group” begin discussions as to how the NERVTAG/ACDP's hasty declassification can be explained/justified. Publish their findings 19 Mar (see sect 2.2 above)
17 Mar ⁴⁵	Chair of Health and Social Care Committee questions Prof Keith Willett (NHS Strategic Incident Director), quoting a London A&E doctor <i>“It's absolute carnage in A&E, utter chaos. We don't have any proper PPE. We are being given paper masks, not the gowns, not the FFP3 masks we need ... I am in shock. I feel like we are being thrown to the wolves here. Some of us are going to die.”</i> To which Prof Willett responds <i>“we have to educate our NHS staff...”</i>

⁴² [Email JVT to K Willett, P Horby, S Hopkins attaching draft IPC guidance](#) (Redactions by DHSC FoI Team)

⁴³ [INQ000381176](#)

⁴⁴ [NHS Central Alerting System \(CAS\) Alert](#) issued by Prof Chris Whitty to all NHS/Public Health 13/3/2020 (click attachment)

⁴⁵ Health & Social Care Select Committee – [‘Oral evidence: Coronavirus – NHS Preparedness’](#), Question Q132 : 17/3/2020

20 Mar	Responding to widespread HCW concern about the downgrade to FRSM, HSE assist IPC Cell with preparation of a 'Frequently Asked Questions' document to reassure them that they would be safe. In this email chain⁴⁶ HSE stress the importance of sending out a clear and accurate message to avoid any further confusion and worry amongst staff and to ensure that HCW safety is ensured. In the draft of the FAQ⁴⁷, 'track changes' shows that HSE request that the term "respirator" be used for FFP3s throughout the document to make a clear distinction from surgical masks. In the final version of the FAQ⁴⁸, IPC Cell (or their superiors) have ignored HSE's request and openly called FFP3s "masks" throughout. Few organisations would dare to disrespect the HSE in this way. Presumably it was thought that HCWs would be alarmed by "respirators" being taken away from them and given "masks" instead. Whereas just switching between one type of "mask" and another wouldn't appear to be such a dramatic change. It may be perceived that a change from an efficient-sounding device like a "respirator" to a "mask" would endanger them, as indeed it did.
26 Mar ⁴⁹	During questioning at the Health & Social Care Select Committee, Rt Hon Paul Bristow MP challenges Prof Yvonne Doyle that the reason for the downgrade was that there was not enough FFP kit to go round. Prof Doyle emphatically denies that was the reason for the downgrade.

It has been interesting to note the various witness statements of senior officials from DHSC, PHE/UK-HSA and NHS who have sought to make it clear that they had nothing to do with the writing of the IPC guidance which downgraded the level of HCW protection. They are too numerous to itemise here, but the Inquiry will no doubt be alert to this unseemly 'blame-game'. Some examples are given below:

Public Health England came in for a lot of unfair criticism simply because they had the links through to the Government website and uploaded the various versions of the IPC guidance as they came through. This was widely interpreted as PHE being responsible for the IPC guidance, simply because they were the ones who published it on the Government website.

One of the most outstanding examples of this was in the oral evidence of JVT where, when asked about HCWs "in the eye of the storm" being denied respirators, his reply was that **"the people who wrote the guidance, Public Health England, felt that the predominant route of infections was droplet and therefore a surgical face mask was adequate"**⁵⁰. Hopefully the above timeline has identified exactly who did write the IPC guidance which took away those respirators that HCWs so badly needed. It certainly was not Public Health England.

In Sir Stephen Powis' witness statement⁵¹ he writes **"PHE drafted and changed the guidance which was approved by NERVTAG. The UK IPC Cell was involved in advising PHE on the operational implications of their decisions to make these changes to the IPC guidance"**. He clearly seeks to shift responsibility for the step-down to FRSM away from his people in NHS-England (including the IPC Cell) and lay it at the door of Public Health England, with the UK IPC Cell simply "advising" PHE about their decisions. This contradicts

⁵².

If we contrast Sir Stephen's evidence with that of Prof Susan Hopkins⁵³ we see that she unambiguously lays responsibility for the step-down to FRSM at the door of **"DCMO Jonathan Van Tam who reviewed, finalised and approved the guidance"** and **"the Four Nations IPC Cell held the pen on the guidance"**. As seen in the above chronology, this was absolutely true.

It certainly seems that there were a great many different fingers 'holding the pen' on the IPC Guidance!

⁴⁶ [Emails between HSE and IPC Cell](#) concerning 'FAQ' for HCWs concerning change from FFP3 to FRSMs – 20 March 2020 (redactions by HSE FoI)

⁴⁷ [Draft of 'FAQ' document](#) (with track changes) with HSE's request that the term 'respirator' be used for FFP3s – 20 Mar 20 (redactions by HSE FoI)

⁴⁸ [Final version of 'FAQ' document](#) (as circulated throughout NHS) : Ignoring HSE request – 20 Mar 2020

⁴⁹ Health & Social Care Select Committee – ['Oral evidence: Coronavirus – NHS Preparedness'](#), Questions Q258/259 : 26/3/2020

⁵⁰ [Oral evidence of Professor Sir Jonathan Van-Tam](#), Module 2, 22 November 2023 (page 231)

⁵¹ INQ000412890 [Stephen Powis, Witness statement #3](#), 7 February 2024, paragraph 379

⁵² [INQ000348134](#)

⁵³ INQ000410867 [Witness statement of Professor Susan Hopkins #1](#), 31 January 2024, paragraph 296

The fact that leaders of these organisations see the need to point the finger of responsibility for the IPC guidance at each other strongly suggests that the IPC guidance was so flawed, so deceiving of the healthcare community and had so many disastrous consequences in terms of causing avoidable ill-health and deaths that no party wished to claim ownership (hence accountability and/or liability). Had the IPC guidance been hailed a massive success[†] which prevented the NHS becoming overwhelmed and saved thousands of lives, one can be certain that each party would gladly accept responsibility, take credit, and bask in the accolades.

The fact that, as far back as 13 March 2020, individuals involved with the preparation of the IPC guidance and the CAS Alert were using the term ‘holding the pen’ in emails where it wouldn’t really seem necessary, strongly suggests they had knowledge (or at least a suspicion) of the increased rates of infection, illness and death likely to afflict health and social care workers as a result of the reduced level of respiratory protection being provided.

[†] Ruth May (Chief Nursing Officer, England) did, in fact, try to hail the IPC measures as a success, claiming it prevented thousands of infections⁵⁴. CATA and many others would beg to disagree. A ‘preprint’ paper was relied upon for this claim⁵⁵. The rubric on the preprint stated that the paper had “**not undergone peer review**” and warned that it “**should not be considered conclusive, not be used to inform clinical practice nor referenced as validated information**”. Furthermore this was a modelling exercise and not based on real-world data.

It is noted that Professor Mark Wilcox co-authored this paper. Prof Wilcox was a highly influential figure who, as the National Clinical Director for IPC, had management oversight (and attended meetings) of the IPC Cell which wrote the IPC guidance which was so enthusiastically celebrated in his paper. The phrase ‘marking one’s own homework’ comes to mind. His paper failed to account for the 14,000 patients who caught Covid-19 in hospitals in England and Wales and died during the first two waves, not to mention the deaths of over 800 healthcare workers. This may be a more fitting testament to the effectiveness of the IPC arrangements in hospitals than the machinations of Professor Wilcox and colleagues’ computers.

Professor Wilcox was the lead author of the SAGE paper S1169 “Masks for Healthcare Workers”, which was robustly criticised in witness evidence to the Commons Health and Social Care Select Committee⁵⁶.

4. Summary Conclusions and Recommendations

Having studied the minutiae of the events which took place during that dark period of our history, which cost more lives than the blitz in World War II, the following observations are offered:

- The errors which caused this nation to be so unprepared for the pandemic have been laid bare in the Inquiry Chair’s report on module 1.
- When it was realised that our front-line HCWs could only be protected with flimsy surgical masks, which are not even legally considered PPE in this country, ministers and officials must have wondered what on earth to do. The disastrous consequences for Italian HCWs were already widely known to UK HCWs who could see the pandemic inexorably sweeping towards them. The spectre of a widespread ‘refusal to treat’ by HCWs is likely to have been a consideration – as seen in the film ‘Contagion’, where HCWs simply abandoned their posts and left the public to their fate. This is a film that the Secretary of State for Health and Social Care is known to have watched and taken some inspiration from⁵⁷.

So our front-line HCWs were given surgical masks, which they were told would keep them safe since the disease was spread only by droplets and not the aerosols produced by coughing, sneezing, talking or simple breathing. This misinformation was communicated to NHS and Local Authorities in a letter which confirmed that fluid repellent facemasks should be worn when within one metre of a suspected or confirmed infectious patient, on the grounds that “**COVID-19 is not airborne, it is droplet carried**”⁵⁸.

⁵⁴ INQ000479043 [Witness statement of Dame Ruth May](#), CNO England, 17 May 2024, paragraph 307

⁵⁵ INQ000330923 [Efficacy of interventions to reduce nosocomial transmission of SARS-CoV-2 in English NHS Trusts](#) (pre-print), 29 Oct 2021

⁵⁶ [‘Initial Lessons from the Government’s Response to the Covid-19 pandemic’](#) – Commons H&SC Select Committee – June 2021, section 10

⁵⁷ [‘Covid: Contagion film shows lessons around vaccine supply – Hancock’](#), BBC, 3 February 2021

⁵⁸ INQ000130506 : [Letter from NHS-E/I, PHE, AMRC to NHS confirming the safety arrangements when caring for patients](#) : 28 Mar 2020

Similar misinformation was communicated to care home workers⁵⁹ as can be seen in figure 2 below:

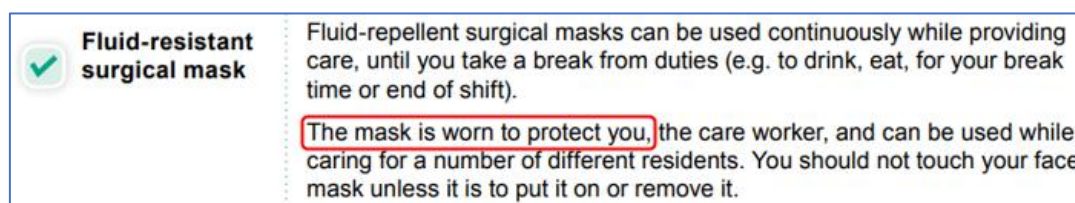


Fig 2 : Extract from official IPC guidance purporting that surgical masks would protect them (*emphasis added*).

- As a health and safety practitioner, we are always taught to seek out the ‘root cause’ of an accident or incident. To my mind, one of the ‘root causes’ is the name “HIGH CONSEQUENCE INFECTIOUS DISEASE”. Admittedly, when it was first introduced, it was probably a very suitable term. However, they hadn’t thought of the consequences when the situation arose for it to be declassified (once the HCID and IDUs had been overrun) as happened with Covid-19:
 - The removal of the term “high consequence” inferred that the disease was of less consequence to health and the level of PPE could be relaxed as a result. Clear evidence of this was found in emails circulating within NHS-England, following the announcement of declassification:
 - When, on 20 March 2020, Professor Keith Willett emails staff in the NHS the new wording on the ACDP website proclaiming it is no longer considered an HCID, one of the recipients forwards onwards with the observation “**We are now no longer defining Covid-19 as a high consequence infectious disease. This makes a big difference to the level of PPE required.**”⁶⁰ No explanation of this was provided.
 - _____

 - The removal of the term “high consequence” may have engendered a false sense of security, although with the Italian HCW experience on their screens, this may seem unlikely. Nevertheless it is a consideration.
 - In another sense, removal of the term “high consequence” may be seen as ludicrous, coming at a time just two days after a global pandemic had been declared, the global death toll had almost reached 5,000 and was on a fast rising trajectory.
 - Although one might say “what’s in a name?”, when the consequences can give rise to misunderstandings and ambiguities perhaps, with the benefit of hindsight, the name “HCID” is not the most appropriate to use. The HCID status does not take into account the level of transmission as experienced during the Covid pandemic such that millions would die globally and almost a quarter of a million UK citizens to date.

One cannot say that just because a disease will only kill 1% of people it infects (*or 2.5% depending on whose CFR figure one accepts*) that we can downgrade the personal protection afforded to healthcare staff since it is relatively low in comparison with other diseases. That contravenes all the moral and ethical principles upon which civilised society is founded, not to mention being contrary to the principles of health and safety legislation and the “right to life” provisions of Article 2 of the Human Rights Act 1998.

Any future planning for a novel airborne pandemic must ensure that the State is not forced into the position of having to accept that hundreds of frontline healthcare workers may have to die or be seriously injured ‘for the greater good’ by denying them RPE in the face of a brutal airborne pathogen against which humans have no natural immunity and are therefore defenceless.

⁵⁹ Public Health England: [How to work safely in care homes](#) : 27 April 2020

⁶⁰ INQ000087332 [email from K Willett distributing the revised wording for HCID status](#). Interpretation this leads to a reduction in the level of PPE

⁶¹ INQ000252515

○ **Recommendation 1:**

In future pandemic planning terminology, consider replacing the term “High Consequence Infectious Disease” with an alternative term such as “Disease with Pandemic Potential” (with sub-definitions “contact” and “airborne” to reflect the different mitigations needed).

- As discussed in section 2.2.3 above, there remains some lingering doubt as to what took place during that ACDP meeting on 13 March 2020.

?

Although the Inquiry has many other pressing matters to address during the course of module 3, it should be a consideration that the public hearings will be viewed by hundreds (if not thousands) of people who have been impacted either by occupational or nosocomial Covid-19 infection i.e. bereaved families of HCWs and patients who have died, together with the patients and staff who survived the disease but have had their lives severely impacted by long-Covid. These people will be watching carefully in the expectation that the Inquiry will determine the exact order of events that occurred during those few days in March 2020 when their lives were turned upside down.

Recommendation 2:

The Inquiry should write to the ACDP Chair and all 14 members of the ACDP present at their meeting on 13th March 2020 meeting, possibly also to the HSE observer/assessors who were present, asking for an account of their recollections of that meeting, with particular reference to the way the Chair explained the request for declassification and whether there was any mention or discussion about PPE issues.

It would be helpful if the Inquiry would disclose the missing document, reference INQ000151594, to Module 3 Core Participants.

- One final question remains unanswered. This relates to the last 3 words given in oral evidence provided by JVT on 22 November 2023. Having been asked the question by Mr Weatherby (KC, Bereaved Families for Justice UK):

“Let me put this to you: was this decision to reduce the protection for healthcare workers because there simply weren’t enough?” ⁶²

To which the answer was:

“Not by me ”

Recommendation 3:

The Inquiry should therefore seek to answer the burning question left hanging in the air:

Well, by whom, then ”

END OF ORIGINAL REPORT (31 JULY 2024)

⁶² [Transcript of public hearing 22 November 2023](#), page 232, line 3

ADDENDUM (March 2026)

5. Intervention of the [REDACTED] Team

It will have been noted from section 2.2.3 and “[Recommendation 2](#)” that questions remained unanswered regarding the order of events relating to communication between Professors Jonathan Van Tam and Tom Evans.

This arose from difficulties that JVT appeared to be having when being questioned by Mr Pete Weatherby KC about his interaction with Professor Tom Evans of the ACDP committee and the declassification of Covid-19 as an HCID. His memory appeared to fail him when asked about the sequence of events during the morning of 13th March 2020.

First, we should consider why this one single document is so important that it warrants this level of detailed considerations. The answer is simple. It is not the document itself which is so important but the question as to whether the Inquiry was misled by anyone. It appears that:

- JVT may have misled the Inquiry by indicating that he had in fact contacted Professor Tom Evans after the meeting had finished and the record in the NERVTAG minutes had been added as a ‘post-meeting note’; and
- The _____
_____. This version of events now seems to be untrue.

For a senior Government official and, the _____ to mislead a Public Inquiry is a very serious and troubling issue which one would hope would also be a concern to the Inquiry Chair.

Further information has now come to light – hence the need for this addendum. First, by way of a recap, so that we can explore the time-line more carefully:

Evidence from the minutes of the two meetings suggested the order of events was as follows:

- NERVTAG learned that JVT had sent revised IPC guidance to the NHS the previous day. This downgraded PPE from FFP3 to FRSM for most routine care of infectious patients (‘Red’ cohorted wards, paramedics etc)
- Members noted that this was contrary to the health and safety rules for HClDs which require FFP3s to be worn and the disease was, at that time, still classified as a HCID.
- JVT was tasked with discussing the issue with Professor Tom Evans (ACDP Chair) and convey NERVTAG’s recommendation that the classification of Covid-19 should be “urgently reconsidered”.
- JVT then contacted Prof Evans who was chairing a concurrent meeting of the ACDP committee. Although no record of that communication is available, it is assumed that JVT did as NERVTAG had asked.
- The ACDP meeting finished its business of the day (transportation of SARS-CoV-2 samples by courier)
- Under ‘Any other business’ Prof Evans informed members that he had been contacted by DHSC regarding the classification of Covid-19 as an HCID (*it is presumed that he meant JVT, being a senior representative of DHSC*). The committee then readily agreed that the disease should be declassified.
- Prof Evans then passed this decision back to Dr Jim McMenamin (another NERVTAG member) who duly relayed it back to his colleagues in NERVTAG whilst their meeting was still in session.

As mentioned in section 2.2.3 above, the letter from the _____ ⁶³,

_____.

⁶³ **INQ000398305**

(INQ000151594). Without sight of this email, it was impossible to determine whether the explanation given by — was reasonable or misleading. So, back in July 2024 when this report was first prepared, the question was left hanging in the air.

As mentioned in ‘[Recommendation 2](#)’ above, the Inquiry was asked to disclose document INQ000151594. Our original report, complete with this request, was sent to the Inquiry on 31 July 2024 by Saunders Law and the Inquiry confirmed safe receipt the next day. However, as the Inquiry disclosed successive tranches of documents to core participants, it didn’t appear. Neither did this report.

Despite requests via Saunders Law for the Inquiry to disclose INQ000151594, it was never forthcoming. Having waited patiently for 8 months and, frustrated by the Inquiry’s refusal to disclose it, the document (the email from Prof Tom to Prof Van Tam, 13/3/2020) was obtained from the DHSC by a Freedom of Information request ⁶⁴.

As can be seen, the email chain is so innocuous and uncontentious that it is difficult to understand why the Inquiry would not disclose it – other than it does support the version of events described in (i) to (vii) above and, when considered together with the other evidence, it reveals the version of events purported by —/JVT to be flawed.

The email, dated 13 March 2020 11:53, was short and to the point:

Dear Both

As it happens was on teleconference with ACDP and unanimous view was the committee would support declassification of infection with SARS-CoV-2 as a HCID
Best wishes, Tom

The email was sent by Prof Evans to JVT and a colleague in NHS. Although the colleague’s name has been redacted, this will almost certainly have been Dr Jim McMenamin since it was Dr McMenamin who then conveyed the ACDP decision back to NERVTAG while their meeting was still in session.

Given that Prof Evans had introduced the topic of declassification under AOB at the **end** of the meeting by informing the committee that he had been contacted by DHSC regarding the HCID classification, there are only 3 possibilities as to when the suggestion about declassification had been put to him (i.e. before, during or after the ACDP meeting). Considering these in turn:

- 1) **Before the meeting:** If someone from DHSC had contacted Prof Evans before the meeting started, asking for his committee to reconsider the HCID classification, this would surely have appeared as a priority on the agenda and been discussed first. Both NERVTAG and SAGE were meeting the same day and would have needed to know the outcome of such an important decision as a matter of urgency.
- 2) **During the meeting:** Just conceivably, someone else from DHSC (other than JVT) could have independently sent a message to Prof Evans whilst the meeting was in progress. However, it is clear from the wording of the email (“*As it happens...*”) that this is a response to a communication which had originated from JVT himself – otherwise there would have had to have been a few words to explain the context.
- 3) **After the meeting:** Given that email was time-stamped 11:53 and the ACDP minutes record the close of the meeting as 12:00 (presumably ‘rounded up’ slightly) it is probable that Prof Evans sent the email virtually straight after the ACDP meeting ended. Besides, just before the end of his meeting, Prof Evans had already told members that the contact with DHSC had already taken place – which rules out the conversation with JVT being afterwards.

Although, through necessity, there is some conjecture involved in the above interpretation of facts, CATA is happy to ‘stand corrected’ if any member of the ACDP committee who attended that meeting (including Prof Evans and the anonymous member interviewed by [David Shukman of BBC](#)) would like to volunteer a detailed account as to what transpired. They are invited to send their account to the Inquiry, with copy to CATA via Saunders Law.

⁶⁴ [E-mail correspondence – Prof Tom Evans \(ACDP Chair\) – Prof Jonathan Van Tam](#) – 13 March 2020

All of this fits perfectly well with the narrative outlined at section 5 (i) to (vii) above.

It appears to have been a purposeful attempt to misdirect the Inquiry away from the fact that NERVTAG/JVT were the ‘prime-movers’ in removing the HCID ‘tag’ from Covid-19 that day, which it urgently needed to do because of the PPE downgrade issued to the NHS via the CAS alert and the fact that it contravened the health and safety rules for HCIDs.

All one can ask is that people be open, honest and transparent about their involvement in the management of the pandemic. They should certainly not seek to mislead the UK Covid-19 Inquiry and core participants.

This has to be seen against the evidence provided by JVT just a few minutes later when, under oath, he asserted that “Public Health England wrote the (IPC) guidance”⁶⁵. This was clearly untrue since, as shown in the timeline at section 3.2 above, on 12th March, he, himself, had finalised and sent the IPC guidance to the NHS, giving it his “DCMO signoff”.

6. Declassification – A final note

For the avoidance of doubt, there was nothing at all wrong with declassifying Covid-19 as an HCID (per se). It could (and arguably should) have been declassified late February 2020 or the first week in March once it was obvious that community transmission rates far exceeded the capacity of the limited HCID and IDU beds available in the UK. Its usefulness in terms of containing the fast-spreading pandemic disease was spent.

This was well explained by Sir Peter Horby (Chair, NERVTAG) in his oral evidence to module 2:

“the purpose of the classification is to mitigate the risk of transmission ... that only makes sense as a measure if there's not already widespread transmission of the virus. Once you have the virus in the community, then those measures make a lot less sense”.

The Inquiry’s IPC Experts Shin, Gould and Warne agreed with the above (as do members of CATA’s Executive Team). The key point arising is that none of the experts have ever stated that declassification of the disease had any bearing on the mode of transmission or the protections for staff and patients in healthcare settings.

This was well illustrated by Dr Jake Dunning, the infectious diseases consultant, the lead member of the “4-nations HCID Definition & List Group” whose deliberations on 16 March 2020⁶⁶ expanded on the ACDP’s hurried declassification six days earlier. Although the paper declassified the disease as an HCID on the grounds of (a) lower Case Fatality Rate than other HCIDs and (b) improved recognition and testing capabilities, it did nothing at all to alter the original classification of “airborne” that he and colleagues had assigned on 10 January.

Dr Dunning clearly had a good understanding of the airborne nature of the disease, having openly expressed his opinion at a Cell meeting⁶⁷ just a few days previously. He observed that ***“providers will need to review ventilation systems when moving (away from single rooms) to cohort areas”*** (text in brackets inserted to provide context). As Mr Jamie Fireman KC insightfully observed during his questioning of Dr Lisa Ritchie (a former Chair of the IPC Cell) during the module 3 public hearings⁶⁸, one wouldn’t recommend ventilation unless one accepted that there is airborne transmission of the disease. It therefore follows by extrapolation, that Dr Dunning accepted airborne transmission when he published his considerations about HCID declassification.

CATA also agrees with the DHSC strategy for future pandemics⁶⁹ that ***“the HCID classification should not be extended beyond the period it is required”***. However, the following qualification needs to be added: ***“The removal of the HCID classification should not, in itself, infer any change to the mode of transmission of the pathogen. Neither should it infer any change to the PPE or other mitigations required for the purposes of health and safety or infection prevention and control.”***

⁶⁵ [Transcript of public hearing 22 November 2023](#), (page 231, lines 22-23)

⁶⁶ INQ000119498 [Review of whether Covid-19 should continue to be classified as a High Consequence Infectious Disease in the UK](#), 19 March 2020

⁶⁷ [Notes of an IPC Cell meeting](#), March 2020

⁶⁸ [Transcript of UK Covid-19 public hearing, oral evidence of Dr Lisa Ritchie](#) : 16 September 2024 (page 113, L 16) : [video](#)

⁶⁹ Technical report on the COVID-19 pandemic in the UK – [Chapter 1: Understanding the pathogen](#) – 10 January 2023

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